

Standard Recommended Procedures for the Emergency Treatment of Sexual Assault Victims

APPENDIX

D

For discussion on sexual assault evidence collection kits, see Section 8.7(A).



MICHIGAN DEPARTMENT OF STATE POLICE

FORENSIC SCIENCE DIVISION

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“A PROUD tradition of SERVICE through EXCELLENCE, INTEGRITY, and COURTESY”

PREFACE

Reports of sexual assaults against adults have continued to increase throughout the past decade, although no one knows for certain how many actual assaults take place each year. Some victims still choose not to report the assault because of embarrassment, fear and trauma as a result of the assault; others lack faith in the follow-up treatment, investigative, and prosecutorial systems. Additionally, there is a wide jurisdictional variance in legal definitions of what constitutes sexual assault. For example, many communities only submit statistics *concerning cases* of forced penetration of a female by a male--*the traditional but very narrow definition of 'rape'*. Others report all types of deviate sexual behavior, including the use of foreign objects and anal or oral copulation.

Reports of child sexual abuse also have increased dramatically in the past few years, although these reports remain even more difficult to document than adult reports. This is due largely to a deficiency in the collection of child sexual abuse data and submission of that data to one central location. The lack of available data is compounded by the low rate of reporting of the abuse by either the victim or a third party.

The reasons for this are extremely complex. Many children are too young to understand that certain kinds of physical contact by adults or older children are inappropriate. Others may realize that something is wrong but are unable to articulate their feelings or are dependent upon the abuser for care. When children do report the abuse to a third party, their story may be dismissed as fantasy or even as a lie. Further complicating the situation is the fact that threats, however subtle, may be made, which discourage reporting by children. Children can be led to believe that something terrible will happen to them or to their families if anyone finds out, or that in some way they themselves are responsible for the abuse.

Traditionally, the successful prosecution of both adult and child sexual assault cases has been difficult. Since the victim often is the only witness to the crime, the collection of physical evidence as well as the documentation of medical trauma may be necessary either to substantiate an allegation or to help strengthen a case for court.

Evidence from the offender and the crime scene often may be found on the body and clothing of the victim. When *immediate medical attention is received, the chances increase that some type of physical evidence will be found.*

Conversely, the chances of finding physical evidence decrease in direct proportion to the length of time which elapses between the assault and the examination.

By necessity, the job of collecting physical evidence in sexual assault cases has fallen to physicians and nurses in hospital emergency rooms and pediatric units. The role of medical personnel in this process often can be the key to successful prosecution and can help to promote early victim recovery.

The primary purpose of this document is to assist hospitals to:

- *minimize the physical and psychological trauma to the victim of a sex crime;*
- *maximize the probability of collecting and preserving the physical evidence for potential use in the legal system; and,*
- *address important issues of current controversy surrounding the collection of medical and physical evidence.*

For the purpose of this protocol, the term 'sexual assault' will be used to refer to all sex crimes perpetrated against adults, and the term 'sexual abuse' will refer to all sex crimes perpetrated against children, both terms being defined in a broad context as follows:

Any act of sexual contact or intimacy performed upon one person by another, and without mutual consent, or with an inability of the victim to give consent due to age, mental, or physical incapacity.

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ADULT PROTOCOL

GENERAL INFORMATION

SENSITIVITY TO VICTIM NEEDS

Some sexual assault victims suffer severe physical injuries, contract a sexually transmitted or other communicable disease, or become pregnant as a result of the attack; many others do not. In each situation, however, victims will experience varying degrees of psychological trauma, although the effects of this trauma may be more difficult to recognize than physical trauma. An individual's perceptions of how sexual assault victims should look, dress, or act, and the way those perceptions are conveyed can have a major effect upon the victim's recovery process in the weeks and months following the crime. Each person has his or her own method of coping with sudden stress. When severely traumatized, victims can appear to be calm, indifferent, submissive, jocular, angry, or even uncooperative and hostile toward those who are trying to help. All of these responses are within the normal range of anticipated reactions. An inappropriate response to information concerning the circumstances surrounding the assault or a misinterpretation of a victim's reaction to the assault may lead to further traumatization and hinder the interview or evidence gathering process.

For some victims, the problems of poverty and discrimination already have resulted in a high incidence of victimization, as well as inadequate access to quality hospital treatment. There may be a mistrust of medical and law enforcement personnel who play a vital role in the aftermath of sexual assault, particularly if there has been a history of unpleasant or disappointing experiences with these professionals.

It is recommended, therefore, that hospitals serving specific populations seek the assistance of reliable community consultants to help develop procedures and counseling resources which will reflect the special needs of those populations.

For example, in certain cultures, the loss of virginity is an issue of paramount importance which may render the victim unacceptable for an honorable marriage; in other cultures, the loss of virginity may not be as great an issue as that of the assault itself.

Also, religious doctrines may prohibit a female from being disrobed in the presence of a male who is not her husband, or forbid a genital examination by a male physician. Such practices are considered a further violation. In such instances, a female physician should be made available for patients who request them.

Age is an important factor to consider when responding to any victim of a sexual assault and when determining the proper method of administering an interview, conducting a medical examination, and providing psychological support.

THE ELDERLY VICTIM

As with most other victims, the elderly victim experiences extreme humiliation, shock, disbelief, and denial. However, the full emotional impact of the assault may not be felt until after initial contact with physicians, police, legal, and advocacy groups, or later, when the victim is alone. It is at this time that older victims must deal with having been violated and possibly diseased, and when they become more acutely aware of their physical vulnerability, reduced resilience, and mortality. Fear, anger, or depression can be especially severe in older victims who many times are isolated, have no confidant, and live on meager incomes.

In general, the elderly are physically more fragile than the young, and injuries from an assault are more likely to be life threatening. In addition to possible pelvic injury and sexually transmitted diseases, the older victim may be more at risk for other tissue or skeletal damage and exacerbation of existing illnesses and vulnerabilities. The recovery process for elderly victims also tends to be far more lengthy than for younger victims.

Hearing impairment and other physical conditions attendant to advancing age, coupled with the initial reaction to the crime, often render the elderly patient unable to make his or her needs known, which may result in prolonged or inappropriate treatment. It also is not unusual for responders to mistake this confusion and distress for senility.

Medical and social follow-up services must be made easily accessible to older victims, or they may not be willing or

able to seek or receive assistance. *Without encouragement and assistance in locating services, many older victims may be reluctant to proceed with the prosecution of their offenders.*

THE DISABLED VICTIM

Criminal and sexual acts committed against the disabled (physically, mentally, or communicatively) generally are unreported and seldom are successfully prosecuted. Offenders often are family members, caretakers, or friends who repeat their abuse because their victims are not able to report the crimes against them.

The difficulty of providing adequate responses to the sexual assault victim are compounded when the victim is disabled. Some have limited mobility, cognitive defects which impair perceptual abilities, impaired and/or reduced mental capacity to comprehend questions, or limited language/communication skills to tell what happened. They may be confused or frightened, unsure of what has occurred, or they may not even understand that they have been exploited and are victims of a crime.

Disabled victims and their families should be given the highest priority. Additional time should be allotted for evaluation, medical examination, and the collection of evidence. The physically disabled victim may be more vulnerable to a brutalizing assault and may need special assistance to assume the positions necessary for a complete examination and collection of evidence. Improvisation from normal protocol may be indicated in some instances.

In sexual assault cases involving the communicatively disabled victim, the use of anatomically correct dolls has proved to be a successful method of communication. Also, under Section 504 of the Federal Rehabilitation Act of 1973, any agency (including hospitals and police departments) that directly receives federal assistance or indirectly benefits from such assistance, must be prepared to offer a full variety of communication options in order to ensure that hearing impaired persons are provided effective health care services. This variety of options, which must be provided at no cost to the patient, also includes an arrangement to provide interpreters who can accurately and fluently communicate information in sign language.

Finally, referrals to specialized support services and reports to law enforcement agencies are particularly necessary for the developmentally and physically disabled who may need protection, physical assistance, and transportation for follow-up treatment and counseling.

THE MALE VICTIM

It is believed the number of adult male victims of sexual assault who report the crime or seek medical care or counseling represents only a very small percentage of those actually victimized. Although many adult males do not seek medical care unless they also have been seriously injured, male child victims are now being seen at hospitals in increasing numbers, in large measure as a direct result of public education and more stringent child abuse reporting laws throughout the nation.

There has been significant progress in educating the public toward understanding the concept of sexual assault of both sexes as being an act of violence; however, there still remains a great reluctance on the part of most male victims to report a sexual assault. Present societal and cultural values can make the trauma of the reporting experience by the male victim at least equal to that of the female victim.

The male victim may have serious problems concerning his inability to resist the assault or confusion about the nature of his role as victim/participant because of a possible involuntary physiological response to the assault, such as stimulation to ejaculation. It is just as important for males as it is for females to be reassured they were victims of a *violent crime* which was not their fault, and that other sexually assaulted males survive to function normally in every way.

Referrals to available therapists or advocacy groups with expertise in the area of sexual assault of males are vital to assist in the recovery process.

INITIAL LAW ENFORCEMENT RESPONSE

Many adult victims of sexual assault will have their first contact following the assault with a law enforcement officer.

The primary responsibilities of this officer are to ensure the immediate safety and security of the victim, to obtain some basic information about the assault in order to apprehend the assailant, and to transport the victim to a designated facility for examination and treatment.

The responding officer should convey the following information to the sexual assault victim:

1. The importance of seeking an immediate medical examination since injuries can go unnoticed or appear at a later time.
2. The importance of preserving potentially valuable physical evidence prior to the hospital examination. The officer should explain to the victim that such evidence can inadvertently be destroyed by activities such as washing/showering, brushing teeth/using a mouthwash, and douching.
3. The importance of preserving potentially valuable evidence which may be present on clothing worn during the assault as well as on bedding or other materials involved at the crime scene. The officer should recommend that a change of clothes be brought along to the hospital in the event clothing is collected for evidentiary purposes.

Although intimate details of the sexual assault itself are not needed at this point in the investigation, a preliminary interview with the victim is necessary so the responding officer can relay information which may be vital to the apprehension of the assailant. The preliminary interview should include the following questions:

1. The extent of injuries, if any, to the victim
2. A brief description of what happened
3. Where the assault took place
4. The identity or description of the assailant(s), if known
5. Where the assailant(s) lives and/or works, if known
6. The direction in which the assailant(s) left and by what means
7. Whether or not a weapon was involved

At the treatment facility, the responding officer should provide the hospital staff with any available information about the assault which may assist in the examination and evidence collection procedures.

TREATMENT PLAN

FACILITY

It is advantageous for all victims of sexual assault to seek both medical treatment and evidence collection from a hospital facility. Physicians who work primarily in private office-based facilities usually do not have evidence collection kits on hand and may not be as familiar as hospital-based physicians with the specific medical and evidence collection procedures relevant to sexual assault victims. Additionally, many private medical offices are not open on a 24-hour basis and may not have equipment available to make the necessary cultures.

Standard Recommended Procedures for the Emergency Treatment of Sexual Assault Victims

Adults should be treated in an emergency room. Children should be treated in a hospital pediatrics unit, if available, because staff in these units are specially trained to treat them. While many jurisdictions have some type of hospital reimbursement plan for sexual assault patients, including the cost of collecting evidence and the collection kit used, victims receiving treatment in private facilities very often will have to be charged.

Hospitals designated to provide sexual assault treatment should have a 24-hour emergency room facility with a staff trained in sexual assault examinations. The ideal situation would also include the on-call availability of a specially trained obstetrician/gynecologist for consultation, the services of a local sexual assault victim advocate, and contingency plans for cases requiring photographs and bite mark impressions.

TRANSFER

If a victim of sexual assault arrives at a hospital that is not equipped to provide a sexual assault examination, arrangements should be made to transfer the victim to the nearest designated treatment facility. However, if there are acute medical or psychological injuries which must be treated immediately, this should be done at the initial receiving facility. A copy of all records, including any X-rays taken, should be transported with the victim to the designated treatment hospital.

Transfer plans should be developed in conjunction with other treatment facilities in the immediate and surrounding community, and the list of designated hospitals should then be provided to all local law enforcement agencies and victim advocacy organizations. This action will greatly reduce the amount of confusion and additional trauma incurred by those victims who are initially taken or referred to a non-treatment facility, as well as reduce the loss of valuable evidence.

INTAKE

The treatment of victims of sexual assault should be considered a medical emergency. Although many victims may not have visible signs of physical injury, they will, at the very least, be suffering from emotional trauma. A private location within the hospital should be utilized, if at all possible, for the preliminary consultation with the victim. This could be a room adjacent to the emergency department or a private office located nearby. In order to prevent others from hearing the conversation, it is recommended this same type of facility be provided for the follow-up law enforcement interview at the conclusion of the examination.

Over the past several years, many hospitals have developed code plans, such as 'Code R' or 'SA' which they use when referring to sexual assault cases. This eliminates the needless embarrassment to victims and/or their families of being identified in the public emergency or examining room setting as the 'rape' or 'sexual assault' victim.

Other methods can be devised to avoid inappropriate references to sexual assault cases, and hospitals are encouraged to develop their own sensitive code plans to ensure privacy.

While the victim is being treated at the hospital, the responding officer should wait in the prescribed waiting area. In some jurisdictions, police protocols call for the officer who accompanies the victim to the hospital to also conduct the follow-up investigation. Officers in these departments should remain at the hospital until the examination is complete before making arrangements to conduct the more in-depth interview with the victim.

REPORTING

Many jurisdictions have mandated reporting laws for violent crimes, including sexual assault. In those instances, local law enforcement authorities are routinely notified by hospital personnel upon arrival of a sexual assault victim. Other jurisdictions leave the decision to report the assault to law enforcement authorities up to the individual victim. In both instances, victims of sexual assault should be encouraged to report and/or cooperate in the police investigation. If victims are reluctant to sign a consent form for the collection of evidence, they should be assured that cooperation in collecting physical evidence will not obligate them to either release that evidence or pursue prosecution of their case.

SUPPORT PERSONNEL

The importance of having a support person available to sexual assault victims *cannot be over emphasized*. Whenever possible, one person should be assigned to stay with the victim throughout the entire emergency department visit.

Well-trained support persons can provide the crisis intervention necessary when victims first enter the hospital for treatment. They can assist hospital emergency room staff in explaining the necessity of medical and evidence collection procedures, and they can counsel family members or friends of the victim who may be at the hospital. A support person also can help provide counseling referrals and other information, such as the existence and availability of victim compensation programs or other types of assistance, emphasize the importance of follow-up testing for possible venereal disease or other medical problems, and answer additional questions victims may have following their medical and evidence collection examinations.

Some hospitals are fortunate enough to have in-house staff who are specially trained to treat victim trauma and who can provide crisis intervention for sexual assault victims and their families. Many of these staff members also are qualified to provide follow-up counseling to victims on a short or long-term basis.

Primarily as a result of the dedication of women involved in the issue of sexual assault, increasing numbers of hospitals have entered into working agreements with victim advocate organizations. These organizations may provide immediate crisis intervention to victims who have arrived at the hospital seeking treatment, as well as follow-up counseling and referrals. In some instances, they also are able to provide support for the victim throughout the entire criminal justice process.

VICTIM/PATIENT CONSENT

Obtaining a patient's written consent prior to conducting a medical examination or administering treatment is standard hospital practice. With the advent of evidence collection requirements and crisis intervention services, sexual assault victims are expected to make a decision about consent to these procedures, as well.

Informed consent should be a continuing process that involves more than obtaining a signature on a form. When under stress, many victims may not always understand or remember the reason for or significance of unfamiliar, embarrassing, and sometimes intimidating procedures. Therefore, all procedures should be explained as much as possible so that the patient/victim can understand what the attending physician and nurse are doing and why.

Although much of the examination and evidence collection process can be explained by the hospital support person or victim advocate, this function is ultimately the responsibility of hospital personnel.

When written consent is obtained, it should not be interpreted as a 'blank check' for performing tests or pursuing questions. If a patient expresses resistance or noncooperation, the physician should immediately discontinue that portion of the process and consider going back to it at a later time in the examination if the patient then agrees. In either event, the patient should have the right to refuse one or more tests or to refuse to answer any question. Having a sense of control is an important part of the healing process for victims, especially at the early stages of examination and initial interviewing.

It is important to remember that consent to have a support person present must be given by the victim/patient prior to the introduction of that person. Also, at any time throughout the treatment and evidence collection process, the patient should be able to refuse further interaction with the designated support person and/or request that the support person leave.

Hospitals should follow their usual procedures for obtaining consent in extraordinary cases, e.g., for severely injured or incoherent patients.

THE EVIDENTIARY AND MEDICAL EXAMINATIONS

The physical examination should be performed in all cases of sexual assault, *regardless of the length of time which may have elapsed between the time of the assault and the examination.*

Some victims may ignore symptoms which would ordinarily indicate serious physical trauma, such as internal injuries sustained by blunt trauma or foreign objects inserted into body orifices. Also, there may be areas of tenderness which will later develop into bruises but which are not apparent at the time of initial examination.

If the assault occurred *within the 72 hours prior to the examination* then an evidence collection kit should be used.

If it is determined that the assault took place *more than 72 hours prior to the examination*, the use of an evidence collection kit is generally not necessary. It is unlikely that trace evidence would still be present on the victim. However, evidence may still be gathered by documenting any findings obtained during the medical examination (such as bruises or lacerations), photographs and bite mark impressions (if appropriate), and statements about the assault made by the victim.

When a forensic examination is performed, it is vital that the medical and evidence collection procedures be integrated at all times. This coordination of medical and forensic procedures is crucial to the successful examination of sexual assault patients.

For example, in order to minimize patient trauma, blood drawn for medical purposes (testing of syphilis) should be done at the same time as blood drawn for evidence collection purposes. Also, when evidence specimens are collected from the oral, vaginal, or rectal orifices, cultures for sexually transmitted disease should be taken immediately following these collection procedures.

ATTENDING PERSONNEL

The only people who should be with the adult victim in the examining room are the examining physician, attending nurse, and, with the consent of the victim, a trained support person. Although every effort should be made to limit the number of people in attendance during the examination, there may be instances when a victim requests the presence of a close friend or family member. If at all possible, these requests should be honored.

Historically, some jurisdictions have sanctioned and even encouraged the presence of law enforcement personnel during the medical examination and evidence collection process. The justification for this presence was the need for officers or investigators to be able to ensure that the specimens were properly collected, labeled, and sealed, as well as testify to the chain of possession in court. *There is no medical or legal reason for a law enforcement representative, male or female, to observe these procedures.* Maintaining the chain of evidence or custody during the examination should be the sole function of the attending medical personnel and one which should require no outside assistance.

Subjecting patients to the observation of law enforcement personnel during this process, as well as having the law enforcement representative privy to the private communications between the victim and the hospital examining/support team, is an invasion of the patient's privacy and is an unnecessary practice.

EVIDENCE COLLECTION DOCUMENTATION

NOTE: *Many of the evidence collection issues apply equally to adult and child victims of sexual assault/abuse, and are discussed in the following sections. However, particular issues regarding the interviewing and medical examination needs of children are discussed beginning on page 31 of this report.*

PACKAGING

In order to prevent the loss of hairs, fibers, or other trace evidence, clothing and other evidence specimens must be sealed in *paper or cardboard containers*. If the containers are plastic, moisture remaining in the evidence items will be

sealed in, making it possible for bacteria to quickly destroy any unstable biological fluid evidence. Unlike plastic, paper ‘breathes’ and allows moisture to escape.

PRESERVING THE INTEGRITY OF EVIDENCE

The custody of any evidence collection kit and the specimens it contains must be accounted for from the moment of collection until the moment it is introduced in court as evidence. This is necessary in order to maintain the legally necessary ‘chain of evidence’, sometimes called ‘chain of custody’ or ‘chain of possession’. Therefore, anyone who handles evidence items should label them with their initials, the date, source of the specimen, the name of the attending physician, and the name of the patient.

IMPORTANCE OF SPERMATOZOA AND SEMEN

The following brief explanation is offered to clarify the importance of spermatozoa and semen and the role each can play in the forensic analysis of sexual assault evidence.

Semen is composed of cells and fluid, known as spermatozoa and seminal plasma, respectively. Historically, medical and law enforcement personnel have placed significant emphasis on the presence of spermatozoa in or on the body or clothing of a sexual assault victim as the most positive indicator of sexual assault. *Conversely, when no spermatozoa were found, a shadow of doubt was sometimes cast upon the victim’s allegation of sexual assault, contributing to the misconception that the absence of spermatozoa meant that no sexual assault occurred.*

The finding of spermatozoa is useful for two reasons:

1. It is positive indication that ejaculation occurred and that semen is present.
2. When spermatozoa are motile (alive), it can be an indicator of the length of time since ejaculation. Although the survival time of spermatozoa in the vaginal, oral, and rectal orifices following ejaculation varies considerably in scientific studies, there is fairly wide consensus that they may remain for up to 72 hours or longer in the vagina (persisting longer in the cervical mucosa), and up to several hours or more in the rectal cavity, particularly if the victim has not defecated since the assault.

Seminal plasma is also useful for two purposes:

1. In the absence of spermatozoa, seminal plasma components (p30 and acid phosphatase) can be used to identify semen. p30 is a prostatic antigen known to exist in the semen of humans and its presence is regarded as a conclusive indication of semen. Acid phosphatase is present in high levels in seminal samples but is considered only a presumptive test for the presence of semen because it also appears in samples that are not seminal in origin, such as vaginal fluid.
2. Most of the genetic markers detected in semen which are used to identify the possible donor are located in seminal plasma.

In the past few years, there has been a dramatic increase in the number of vasectomies. Inasmuch as seminal plasma is produced in the ejaculates of all males, vasectomized or not, the forensic examiner is especially interested in the presence of seminal plasma. DNA analysis can be performed on seminal plasma.

Many sexual assault offenders are sexually dysfunctional and do not ejaculate during the assault. Additionally, offenders may use a prophylactic, have a low sperm count (frequent with heavy drug or alcohol use), ejaculate somewhere other than in an orifice or on the victim’s clothes or body, or fail to ejaculate if the assault is interrupted. *Therefore, a lack of spermatozoa is not conclusive evidence that an assault did not occur; it only means that spermatozoa may have been destroyed after being deposited or that they may never have been present.*

Furthermore, the absence of semen means only that no ejaculation occurred, for the reasons described above, or that various other factors contributed to the absence of detectable amounts of semen in the specimen. For example, there could have been a significant time delay between the assault and the collection of specimens, penetration of the victim could have been made by an object other than the penis, the victim could have inadvertently cleaned or washed away the semen, or the specimens could have been collected improperly.

Therefore, although the finding of semen, with or without the presence of spermatozoa, may corroborate the fact that sexual contact did take place and make a stronger case for the prosecution, its presence is not an absolute necessity for the successful prosecution of a sexual assault case.

CLOTHING EVIDENCE

Frequently, clothing contains the most important evidence in a case of sexual assault. The reasons for this are twofold:

1. Clothing provides a surface upon which traces of foreign matter may be found, such as the assailant's semen, saliva, blood, hairs, and fibers, as well as debris from the crime scene. While foreign matter can be washed off or worn off the body of the victim, the same substances often can be found intact on clothing for a considerable length of time following the assault.

Damaged or torn clothing may be significant. It may be evidence of force and can also provide laboratory standards for comparing trace evidence from the clothing of the victim with trace evidence collected from the suspect and/or the crime scene.

2. The most common items of clothing collected from victims and submitted to crime laboratories for analysis are underwear, hosiery, blouses, shirts, and slacks. There also are instances when coats and even shoes must be collected.
3. In the process of criminal activity, different garments may have contact with different surfaces and debris from both the crime scene and the assailant. Keeping the garments separate from one another permits the forensic scientist to reach certain pertinent conclusions regarding reconstruction of criminal actions. For example, if semen in the female victim's underpants is accidentally transferred to her bra or scarf during packaging, the finding of semen on those garments might appear contradictory to the victim's own testimony in court of exactly what events occurred in the assault.

Therefore, each garment should be placed separately in its own bag to prevent cross-contamination from occurring.

4. Prior to the full examination, great care must be taken by the attending physician or nurse to determine if the patient is wearing the same clothing he or she wore during or immediately following the assault. If so, the clothing should be examined for any apparent foreign material, stains, or damage. When the determination has been made that items may contain possible evidence related to the assault, with patient consent, those items should be collected.
5. If it is determined that the patient is not wearing the same clothing, the attending physician or nurse should inquire as to the location of the original clothing, such as at the victim's home or at the laundry for cleaning. *This information should then be given to the investigating officer so he or she can make arrangements to retrieve the clothing before any potential evidence is destroyed.*

Collection Procedures

To minimize loss of evidence, the patient should disrobe over a white cloth or sheet of paper. If patients cannot undress on their own, and due to their condition it is necessary to cut off items of clothing, be sure not to cut through existing rips, tears, or stains.

Any foreign materials found should be collected and put into a small paper envelope, properly labeled and sealed with cellophane tape.

If the patient consents, the clothing should then be collected and packaged in accordance with the following procedures:

- After air drying items, such as underpants, hosiery, slippers, or bras, they should be put into small paper bags. *It is important to remember that infant diapers may also be valuable as evidence because they may contain semen or pubic hairs.* Items such as slacks, dresses, blouses, or shirts should be put into larger paper bags.
- Any wet stains, such as blood or semen, should be allowed to air dry before being placed into paper bags. It is preferable that each piece of clothing be folded inward, placing a piece of paper against any stain, so that the stains are not in contact with the bag or other parts of the clothing.
- If, after air drying as much as possible, moisture is still present on the clothing and might leak through the paper bag during transportation to the crime laboratory, the labeled and sealed clothing bags should be placed inside a larger plastic bag *with the top of the plastic bag left open.* In these instances, a label should be affixed to the outside of the plastic bag, *which will alert the crime laboratory that wet evidence is present inside the plastic bag.* This will enable the laboratory to remove the clothing and avoid loss of evidence due to putrefaction.

SWABS AND SMEARS

The purpose of making smears is to allow the forensic analyst to test microscopically for the presence of spermatozoa. If no spermatozoa are present, the analyst will then proceed to use the swab(s) to identify the seminal plasma components to confirm the presence of semen.

Depending upon the type of sexual assault, semen may be detected in the mouth, vagina, and rectum. However, embarrassment, trauma, or a lack of understanding of the nature of the assault may cause a victim to be vague or mistaken about the type of sexual contact which actually occurred. Because of these reasons and because there also can be leakage of semen from the vagina or penis onto the anus, even without rectal penetration, it is recommended that the patient be encouraged to allow examination of all three orifices and specimens collected from them.

In cases where a victim insists that contact or penetration involved only one or two orifices (or in some circumstances, no orifices at all), it is important for the victim to be able to refuse these additional tests.

This 'right of refusal' also will serve to reinforce a primary therapeutic principle—that of returning control to the victim.

When taking swabs, the examiner should take special care not to contaminate the individual collections with secretions or matter from other areas, such as vaginal to rectal or penile to rectal. Such contamination may unnecessarily jeopardize future court proceedings.

If victims must use bathroom facilities prior to the collection of these specimens, they should be cautioned that semen or other evidence may be present in their pubic, genital, and rectal areas and to take special care not to wash or wipe away those secretions until after the evidence has been collected.

A pencil should be used when labeling frosted-end slides to lessen the chance that the labeling information will become smudged. It is suggested that pencils contain hard lead and are pre-sharpened, eliminating the need for hospital staff to worry about pencil sharpening during the examination.

Oral/Collection Procedures

The oral smear can be as important as the vaginal or rectal smears. The purpose of this test is to recover seminal fluid from recesses in the oral cavity where traces of semen could survive. *This test should be done first*, so that the patient can rinse out his or her mouth as soon as possible. Such a practice will reduce a significant source of unnecessary patient distress.

Standard Recommended Procedures for the Emergency Treatment of Sexual Assault Victims

The oral smear is prepared by using two cotton swabs together and swabbing the mouth. Attention should be paid to those areas of the mouth, such as between the upper and lower lip and gum, where seminal material might remain for the longest amount of time.

The material from the swabs should be gently rubbed onto a glass slide which has been labeled in pencil and contains the word 'oral' to indicate the source of specimen. After the slide has been placed in a cardboard mailer, it should be allowed to air dry before sealing. The slide should not be fixed or stained.

When the oral swabs have air dried, they should be placed in the envelope labeled "Oral Swabs" and sealed.

Vaginal/Collection Procedures

When collecting the vaginal specimens, it is important not to aspirate the vaginal orifice or to dilute the secretions in any way.

The vaginal smear is prepared by using two cotton swabs together and swabbing the vaginal orifice.

The examiner must be sure that the frosted-end slide is properly labeled and includes the word 'vaginal' to indicate the origin of the specimen. After the glass slide has been placed back into the mailer, it should be air dried before sealing. Again, the slide should not be fixed or stained.

After the label specifying 'vaginal smear' has been affixed to the mailer, the mailer should then be sealed all around with tape.

The vaginal cotton swabs must be allowed to air dry before being placed in the envelope. They should then be labeled and sealed as was done for the oral swabs.

Immediately following this procedure, the pelvic examination should be performed and medical cultures taken.

Penile/Collection Procedures

For the male victim (both adult and child), the presence of saliva on the penis could indicate that oral-genital contact was made; the presence of vaginal secretions could help corroborate that the penis was introduced into a vaginal orifice; and feces or lubricants might be found if rectal penetration occurred.

The proper method of collecting a penile smear is to slightly moisten two cotton swabs with distilled water and thoroughly swab the external surface of the penile shaft and glans. All outer areas of the penis and scrotum where contact is suspected should be swabbed.

These swabs are not, however, for use in the medical diagnosis of a sexually transmitted disease; *therefore, they should not be used to swab inside the penile opening at this time.*

The swabs should be gently rolled over one of the glass slides which is then placed in a mailer. Again, the examiner should not fix or stain the slide. When labeling and sealing the slide mailer, the instructions given for the oral, vaginal and rectal smears should be followed.

When the penile swabs are air dried, they should be placed in the envelope.

It is at this time that swabs should be made for detection of possible sexually transmitted disease.

Rectal/Collection Procedures

The rectal smear is prepared by using two cotton swabs at the same time and swabbing the rectum. To minimize discomfort for the patient, these swabs should be moistened slightly with distilled water.

After preparing the slide, it should be placed in the cardboard mailer, allowed to air dry, then affixed with a label and sealed.

After the rectal swabs have air dried, they should be placed in the envelope and labeled in the same manner as the oral, vaginal, and penile swabs.

At this time, any additional examinations or tests involving the rectum should be conducted.

Other Dried Fluids/Collection Procedures

Semen and blood are the most common secretions deposited on the victim by the assailant. There also are other secretions, such as saliva, which can be analyzed by laboratories to aid in the identification of the perpetrator.

It is important that the medical team examine the victim's body for evidence of foreign matter, and that a swab be taken and a smear made for each separate secretion.

If secretions, such as dried blood or seminal fluid, are observed on other parts of the patient's body during the examination, the material should be collected by taking a smear and a swab. A different swab and smear should be used for every secretion collected from each location on the body.

Dried secretions are collected by moistening the swab slightly with distilled water and swabbing the indicated area. After the smear is taken and the slide prepared, the slide should be returned to the mailer and allowed to dry; then the mailer should be labeled and sealed with tape.

BITEMARK EVIDENCE

Bitemarks may be found on patients as a result of sexual assault and other violent crimes and should not be overlooked as important evidence. Bitemark impressions can be compared with the teeth of a suspect and can sometimes become as important, for identification purposes, as fingerprint evidence. The collection of saliva and the taking of a photograph of the affected area are the minimum procedures which should be followed in cases where a bitemark is present.

Saliva, like semen, demonstrates blood group factors characteristic of their donor. Therefore, the collection of saliva from the bitemark should be made prior to the cleansing or dressing of any wound. If the skin is broken, swabbing of the actual punctures should be avoided when collecting dried saliva.

It is important that photographs of bitemarks be taken properly. It is recommended that a representative of the local law enforcement agency be contacted when the hospital protocol is developed to provide the proper instructions on how to take photographs of bitemark evidence.

In many bitemark cases it is also vital to have a three-dimensional cast made. Whenever possible, a dentist or a forensic odontologist should be called in to examine the bitemark, make the cast and further document findings. Hospitals should either contact their nearest crime laboratory for a listing of qualified forensic odontologists who can assist in this process or the American Board of Forensic Odontology, Inc., which can furnish a list of their members.

Collection Procedures

Saliva is collected from the bite mark area by moistening a swab with distilled water and gently swabbing the affected area, following the same procedures as instructed for other dried fluids.

To demonstrate the size of the bite mark, a ruler should be placed adjacent to but not covering the bite mark, and then photographed.

HAIR EVIDENCE

Hairs occur in three growth stages: anagen (actively growing), catagen (resting stage), and telogen (ready to be shed). There are subtle morphological differences which can be detected by a trained microscopist as the growth stages progress.

During an assault, the hairs most likely to be transferred from suspect to victim or victim to suspect tend to be telogen. Other hairs transferred during an assault are pulled out by friction or other means of forcible removal. Most of these hairs tend to be anagen or catagen.

Known hair samples from the head and pubic regions of the body usually are obtained by using one or more of the following techniques:

1. Samples are taken by using only the procedure of pulling out the hairs. This technique does obtain full length hairs, but only about 10% of these are typically in the telogen growth stage. However, the procedure of pulling is the best method to obtain an adequate sampling of anagen and catagen hairs.
2. Samples are taken by using only the combing procedure. This technique does tend to remove hairs in the telogen growth stage, but can result in a very small number of known hairs being sampled. Combing results in the collection of potential foreign hairs from the assailant together with loose telogen hairs from the victim. This is useful for collecting foreign hairs but is of limited value for the collection of an adequately representative sample of known hairs from the victim.
3. Samples are taken separately by combing and pulling out the hairs. This technique results in obtaining telogen hairs as well as actively growing hairs which will exhibit roots. These roots can be used as an integral part of a forensic comparison of questioned and known hairs. This procedure generally is regarded by forensic analysts as the best alternative for forensic comparisons.

At the present time, however, experts are able to conclude only that samples are consistent with, not consistent with, or inconclusive when compared to another sample. The possibility that hair standards might yield some material evidence for the prosecution is outweighed by the further pain and trauma that the pulled hair procedure causes the victim. Furthermore, given the low percentage of suspects who are apprehended or prosecuted or in which the identity of the suspect is an issue, it is unnecessary to subject every victim to this often painful and humiliating experience.

It is recommended, therefore, that head and pubic hairs be collected by the combing method only, that they not be cut, and that standards be pulled at a later date only if a suspect is apprehended, the prosecution requests these samples, and the victim consents to the procedure.

Collection Procedures

Combing

The top, back, front, and sides of the patient's head hair should be combed over a piece of paper to collect all loose hairs and fibers. The combings *and the comb* are to be placed in an envelope marked 'head hair combings'; the labeling information should then be completed and the envelope sealed with tape.

A second comb should be used to collect any loose hairs or fibers from the pubic area over a piece of paper or paper

towel. *Patients may prefer to do the combing themselves to reduce embarrassment and increase their sense of control.* The pubic hair combings *and the comb* are placed in a second envelope marked 'Pubic hair combings'. After the labeling information is completed the envelope should be sealed with tape. Combing should be done vigorously and thoroughly to lessen the chance that valuable evidence may be missed.

Where there is evidence of semen or other matted material on pubic or head hair, it may be collected in the same manner as other dried fluids. The swab should then be placed in a small paper envelope and labeled 'possible secretion sample from head (pubic) hair'. Although this specimen also can be collected by cutting off the matted material, *it is important to obtain the patient's permission prior to cutting any significant amount of hair.*

Pulled Standards

If a suspect is apprehended and the prosecution requests that head and pubic hair standards be obtained from the victim for comparison purposes, upon consent of the victim, the following procedures should be followed:

A standard sample of no more than 25 head hairs should be collected, consisting of 5 hairs pulled from each of the following areas: back, top, front, left side, right side. To minimize patient discomfort, the attending physician or nurse can pull the hairs, 2 or 3 at a time, using the thumb and forefinger. *Forceps should not be used.* The pulled head hairs should be placed into an envelope, which is then labeled and sealed with tape.

A standard sample of no more than 12 pubic hairs should be collected from various areas of the pubic region. The hairs should be plucked 2 or 3 at a time with thumb and forefinger or, if the patient wishes, he/she can perform this procedure. The pulled hairs should be placed into an envelope which is then labeled and sealed with tape.

The absence of pubic hair should be noted.

WHOLE BLOOD SPECIMEN

In many cases of sexual assault, blood will be found on the offender, the offender's clothes, and/or at the crime scene. Blood may also be found on the victim or the victim's clothing. The purpose of collecting whole blood is to determine the victim's blood group (inherited factors appearing in blood and certain body fluids, also known as genetic markers).

In view of the additional medical requirement to collect blood to test for sexually transmitted disease, only one tube should be used for evidence collection purposes.

Collection Procedures

For adults, 5–7 milliliters of blood should be collected in a EDTA purple-top blood tube. A white label should then be affixed to the blood tube.

In order to minimize patient discomfort, blood needed for the VDRL should also be collected at this time; however, any additional blood or other specimens collected to determine possible sexually transmitted disease are to remain at the hospital for processing.

It is important that collected whole blood samples be refrigerated but not-frozen.

SALIVA SPECIMENS

In the ABO analysis of secretion mixtures, such as semen and vaginal secretions, the ABO type of the victim must be identified in order to evaluate properly the blood type of the other contributor. A dried sample of known saliva and the known liquid blood sample are used to determine the ABO secretor status of the victim.

Filter paper discs should be used for the collection of the saliva sample. Unlike gauze pads, filter paper air dries quickly. Also, the loose weave structure of some gauze pads tends to disperse the saliva, making it more difficult to analyze.

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Collection Procedures

It is important that this specimen not be contaminated by outside elements. Therefore, the victim should not smoke or have anything to eat or drink for at least 30 minutes prior to this procedure.

The examiner should collect a saliva sample by using a filter paper disc which is already packaged in a small, pre-sealed envelope. The patient should manually place the disc in his or her mouth, saturating it with saliva. Labeling information on the envelope is then to be completed.

Patients should be reminded not to chew the disc; moistening it for a few seconds usually is sufficient. Patients should also be instructed to remove the disc with their own fingers. *The disc must not be removed by anyone other than the patient unless a hemostat is used*, because the slightest *contamination from* another person's secretions may be detected by the forensic analyst.

When dry, the disc should be completely inserted back into the envelope and the envelope sealed with tape.

MEDICAL EXAMINATION DOCUMENTATION

BODY DIAGRAMS/PHOTOGRAPHS (FSD 97 FORM)

Photographs of sexual assault victims *should not be taken on a routine basis*. Instead, drawings of the human figure should be used to show the location and size of the injury, as well as a written description of the trauma. Drawings should consist of both adult and child figures and contain genitalia for males and females.

Photographs of extremely brutal injuries and of bite marks can prove quite beneficial in court; however, many times injuries, such as bruises, will become apparent only after several days. There is no guarantee that photographs will develop to show the actual severity of the injury. Once taken, photographs can be subpoenaed into evidence and may hurt the case if actual injuries appear minimal or cannot be seen.

Therefore, any photographs which are taken *should be limited to those instances where there is an opportunity to produce clear pictorial evidence of injury*, such as bruises or lacerations. Also, if photographs are taken, they should be done only with the specific consent of the patient.

Further, *photographs should not be taken of the genital areas* unless the victim specifically requests this procedure, because of added trauma to the victim during the examination, as well as probable and unnecessary embarrassment in court. Again, drawings accompanied by accurate written descriptions can be as effective in court as photographs.

Finally, it is vital that all photographs be taken by a competent photographer, preferably of the same sex as the patient, and that a ruler and color chart be used to indicate the size and nature of each injury.

TERMINOLOGY

Findings from the physical examination should be documented as completely as possible on the medical record. Sexual assault prosecutions may not always require the presence or testimony of the attending physician or nurse, however, there will be times when it is necessary. If testimony is needed, *a thoroughly completed and legible medical record and accompanying body diagram* will assist medical staff in recalling the incident.

When gathering information necessary to perform the medical and evidentiary examination, the attending physician must be careful not to include any subjective opinions or conclusions as to whether or not a crime occurred. The indiscriminate use of the term 'rape' or 'sexual assault' on a medical document is a conclusion that may prejudice future legal proceedings. Instead, the medical chart should reflect that a sexual assault examination was conducted and should include any pertinent medical findings.

An important distinction must be made between information gathered for the purpose of providing medical treatment and that which is gathered for the follow-up investigation and potential prosecution. Hospital personnel should not be

expected to further expand their role to act as an ‘investigator’ for law enforcement. They should not ask for details *beyond those necessary* to perform the medical and evidence collection tasks; it is the responsibility of the follow-up investigator to ask the more detailed questions.

DATE OF LAST VOLUNTARY COITUS

When analyzing semen specimens in sex-related crimes, forensic analysts sometimes find genetic markers which are inconsistent with a mixture from only the victim and the defendant. A mixture of semen from a defendant and the victim’s previous sexual partner could lead to blood grouping results which, if unexplained, could conflict with the victim’s own account of the assault.

Many forensic analysts request that physicians ask victims if they engaged in voluntary sexual intercourse within several days prior to the assault. If so, victims are then asked the date of the contact in order to help determine the possible significance of semen remaining from the prior sexual contact.

The fact that the date of last voluntary coitus can be of value in the forensic analysis of specimens submitted to a crime laboratory is not disputed. An issue arises, however, as to whether all sexual assault victims should be asked to provide this information at the time of initial examination or whether they should only be asked *if and when a mixture of body fluids is found*.

Legally, the victim’s prior sexual activity and/or date of last coitus with a person other than the defendant, unless needed for medical purposes, is information which is completely unnecessary for the successful prosecution of a case, and in fact, is information which infringes upon privacy rights guaranteed by most rape shield statutes. In addition, while in a traumatized state, many victims may be unable to recall the date of their last voluntary coitus.

Very often, when the date of last voluntary coitus is asked during the physical examination, the identity of the sexual partner is also solicited as a matter of record.

Knowing who the prior sexual contact was is significant only to the extent that saliva and blood samples from the individual involved can be made available for comparison. Therefore, this person’s identity is not relevant either to the medical examination *or* for the initial findings of the crime laboratory and should not be sought at time of initial examination.

The need to know the date of the victim’s last voluntary coitus in conjunction with the patient’s menstrual history should be solely for medical purposes in determining the possibility of pre-existing pregnancy in females who are of child-bearing age and who may be at risk for pregnancy.

It is recommended that sexual assault victims be asked the date of their last voluntary coitus only on a need-to-know basis. If a suspect is apprehended and the crime laboratory finds genetic factors which cannot be attributed to either the offender or the victim, then it is appropriate for the follow-up police investigator to inform the victim of this fact and ask whether any voluntary coitus took place within 72 hours prior to the assault and with whom.

The opposing view to this recommendation is that certain facts must be made known to the forensic scientist concerning the recency of any previous voluntary coitus in order to avoid incorrect conclusions in assessing the possible inclusion or exclusion of the suspected assailant.

Factors which can influence the interpretation of the scientific findings include the following:

1. Semen can remain in the vagina from several hours to several days, and for shorter periods of time also can be found in the rectal orifice, particularly if the patient has not defecated since the assault. Although the majority of sexual assault cases involve detectable semen lasting up to 72 hours, the disappearance of semen from the vaginal or rectal orifice usually is gradual, not sudden. The amount of residual semen can be extremely variable, depending on the victim's own peculiar physiology, any cleansing activities following coitus, the original volume of semen, the effectiveness of the medical collection procedure, and the sensitivity of the analytical method employed by the crime laboratory.

If the victim has had recent voluntary coitus, then the ejaculate of that sexual partner could be present on the specimen and not necessarily be that of the assailant. In order to interpret the results correctly (to avoid falsely excluding the assailant as the donor of the semen or falsely including an innocent party), analysis of genetic markers in the sample requires knowing the genetic markers of all those persons who could have contributed to the sample.

2. The recollections of the victim may become less accurate if they go unsolicited until after the crime laboratory identifies discrepancies between the assailant's known blood type and the blood type of the seminal stains. In some jurisdictions, several months may elapse between the initial medical examination, the crime laboratory analysis, and the follow-up interview with the prosecutor and victim.

MEDICAL REPORT FORM FOR SEXUAL ASSAULT EXAMINATION (FSD 97, PAGE 2 &3)

Throughout the evaluation and medical examination, the attending physician should explain to the patient why questions are being asked, why certain medical and evidentiary tests may need to be performed, and what treatment, if any, may be necessary.

1. Vital signs and other initial information, such as the date and time of *both* the examination and the assault, should be recorded.
2. A brief description of the medical details of the assault should be recorded. This description should include any oral, rectal, or vaginal penetration, whether the assailant penetrated the victim with finger(s) or foreign object(s), whether any oral contact occurred, and whether ejaculation occurred (if known). The patient's account of what happened should be recorded accurately, briefly, and in the patient's own words as much as possible.
3. Information regarding the physical location of the assault should be recorded (i.e., car, rug, grass, alley). This information will assist the physician with an indication of where to look for evidence and what evidence to collect such as hairs, fibers, or other trace material.
4. Significant medical history of the patient should be recorded. This would include any allergies, current medication, acute or chronic illness, surgery, and any post-assault symptoms such as bleeding, pain, loss of consciousness, nausea, vomiting, or diarrhea.
5. Gynecological history information including menstrual history (last menstrual period, date and duration, menstrual cycle), pregnancy history (including evaluation of possible current pregnancy), and contraceptive history should be evaluated and recorded. In patients at risk for pregnancy, a urine pregnancy test should be done to establish a baseline for possible *pre-existing* pregnancy. (The urine sample can also be examined for trichomonas).
6. During the general physical examination, record all details of trauma, such as bruises, abrasions, lacerations, bite marks, blood or other secretions, with particular attention paid to the genital and rectal areas of both male and female patients. Common sites and types of injury, even if not yet visible, include the breasts, the upper portion of the inner thighs, grab or restraining marks on the arms, wrists or legs, and injuries or soreness to the scalp area, back or buttocks as a result of being thrown against an object or onto the ground.

NOTE: Information concerning sexually transmitted diseases is contained on pages 42–45 of this report. However, it is recommended that if penicillin is to be given as prophylaxis, it should not be delayed until the very end of the patient's hospital examination. Because some patients may be allergic to penicillin but unaware of their allergy, it is recommended that this treatment, if provided, be administered in time to allow for at least 30 minutes of patient observation.

PROCEDURES FOR RELEASE OF EVIDENCE (FSD 97, PAGE 1)

PRELIMINARY PROCEDURES

When all evidence specimens have been collected, they should be placed back into the kit, making certain that everything is properly labeled and sealed. *Again, any unused kit components or medical specimens collected for non-evidentiary purposes should not be included in the kit.*

The original copy of the Release of Information and Evidence is to be included in the completed kit and the second copy retained for the hospital records.

All required information should then be filled out on the top of the kit just prior to sealing it with red or orange evidence tape at the indicated area. The completed kit and clothing bags should be kept together and stored in a safe area. Paper bags are to be placed next to but not inside the completed kit.

TRANSPORTATION OF EVIDENCE

Under no circumstances should victims be allowed to handle evidence after it has been collected. Only a law enforcement official or duly authorized agent should transfer.

RELEASE OF EVIDENCE

Evidence collection items should not be released from a hospital without the written authorization and consent of the informed adult patient or an authorized third party acting on the patient's behalf if the patient is unable to understand or execute the release. An Authorization for Release of Information and Evidence Form should be completed, making certain that all items being transferred are checked off. In addition to obtaining the signature of the patient or authorized third party on this form, signatures must be obtained from the hospital staff person turning over the evidence, as well as the law enforcement representative who picks up the evidence.

One copy of the release form should be kept at the hospital and the other copy given to the law enforcement representative. This representative should also print and sign his or her name on the cover of the collection kit and bags of clothing and fill in the time of transfer.

NON-AUTHORIZATION OF RELEASE

Although the vast majority of sexual assault victims consent to have their evidence specimens released to law enforcement subsequent to the medical examination and evidence collection process, there may be instances when a victim will not authorize such a release. Hospital and/or law enforcement personnel should not react negatively to a victim's initial decision not to release evidence. They should inform the victim that the release of evidence is not a commitment to prosecute. Although the lack of authorization on the date of collection could later be questioned if the case goes to court, such reluctance can be explained easily and is not considered by prosecutors to be a serious problem.

If consent is not initially received, kits and clothing bags be stored on a temporary basis in a locked, secure area. To retard spoilage, kits should be refrigerated for up to two weeks, if possible, before being destroyed. (Although some hospitals have limited storage and/or refrigeration facilities, space should not present any major problem since the number of actual cases in which release is not authorized is very low.) Hospital personnel and/or victim advocates must inform victims of the length of time the evidence will be held prior to destruction, thereby providing the victim with an opportunity to reconsider authorization for release within a reasonable period of time after the initial hospital examination.

POST-EXAMINATION INFORMATION

PATIENT TREATMENT FORM (FSD 97, PAGE 4)

The discussion of follow-up services for both medical and counseling purposes is an important treatment aspect for

Standard Recommended Procedures for the Emergency Treatment of Sexual Assault Victims

sexual assault victims. Before the patient leaves the hospital, a *Patient Treatment Form* should be completed. The type and dosage of any medication prescribed or administered should be recorded on the first portion of this form.

Many hospitals report that the majority of sexual assault victims *do not return* to the facility for these follow-up tests. Denial of the assault or of the need for follow-up testing, especially if no unusual symptoms are experienced, and inadequate information provided by many hospitals concerning the necessity for follow-up treatment are common reasons for a failure to return.

Patients should be encouraged to obtain follow-up tests for possible pregnancy, sexually transmitted disease, and urinary tract or other infections, *within four to six weeks after the initial hospital visit*. It is vital that both written and verbal information be provided, including the locations of public health clinics or referrals to private physicians for medical follow-up if the patient does not wish to return to the treating hospital. Victim advocates can be quite helpful in explaining the need for a return visit and what types of tests should be performed.

The second portion of the patient information form should be used to record follow-up counseling information. While the patient should be encouraged to seek follow-up counseling, the decision to do so must be voluntary. Some victims may be reluctant to talk with a counselor; however, they are more likely to participate if counseling has been coordinated with the examination process. An appointment with a trained hospital counselor should be recommended and scheduled. A referral to a victim advocate, social worker, or psychologist in the community who is known to provide quality service could also be made.

The original copy of the patient information form should be given to the patient and the second copy retained for the hospital's records.

FOLLOW-UP CONTACT

Any further contact with sexual assault victims must be carried out in a very discreet manner. In an effort to avoid any breach of confidentiality or unnecessary embarrassment, it is recommended that victims be asked, prior to leaving the hospital, whether or not they can be contacted about follow-up services. If so, they should be asked to provide an appropriate mailing address and/or telephone number where they can be reached.

INFORMATIONAL BROCHURES (FSD-97-D)

Many victim advocacy agencies and individual hospitals have developed informational brochures about sexual assault and its aftermath. These brochures can be helpful in explaining to patients some of the common problems they may encounter, such as disturbances in sleeping or eating patterns, flashbacks of the attack, and post traumatic stress syndrome. They also can provide reassurance to the patient that sexual assault victims are not responsible for the assault.

In addition, brochures should contain information about local or state resources such as victim compensation programs, counseling services, and information on home security and personal safety. If at all possible, arrangements should be made to provide a copy of such publications to sexual assault patients and their families when they leave the hospital.

CLEAN-UP/CHANGE OF CLOTHING

Many patients would like to wash after the examination and evidence collection process. If possible, the hospital should provide the basics required, such as mouth rinse, soap, and a towel.

If garments have been collected for evidence purposes and no additional clothing is available, arrangements should be made to ensure that no victim has to leave the hospital in an examination gown. In those instances where police officers transport victims from their homes to the hospital, officers should be instructed to advise victims to bring an additional set of clothing with them in the event any garments are collected. Some patients may wish to have a family member or friend contacted to provide substitute clothing. When the victim has no available personal clothing, necessary items could be supplied by hospital volunteer organizations and/or local victim assistance agencies.

Hospitals can address this issue by developing a community plan with local law enforcement agencies and victim assistance organizations.

LAW ENFORCEMENT INVESTIGATIVE INTERVIEW

Many police departments, especially within large metropolitan areas, have investigators or detectives whose duties include sexual assault investigations. These officers do not answer the initial call but rather enter the case after the responding officer has written his/her initial report. Upon arrival at the hospital, the investigator should talk with the responding officer and/or attending hospital staff to obtain information about the assault and the condition of the victim.

In most cases, the investigator will conduct the follow-up interview after the victim already has been interviewed by the responding officer and the hospital staff. *Therefore, it is very important that the need for this third interview be explained to the victim, especially the reason why more detailed questions must be asked.* Intimate details of the attack may be traumatic and embarrassing for the victim to recall. However, the details provide information that the investigator must have in order to get an accurate picture of the circumstances surrounding the case and to prepare a report for the prosecutor.

General guidelines for this interview include the following:

1. The interview should be conducted *after the medical examination and evidence collection procedures have been completed*. In some cases, it may be necessary to delay this interview for several hours or longer. Often, delays at hospitals are caused by the length of time necessary for the medical examination and determination by emergency room staff as to the victim's 'readiness' for such an interview. The follow-up investigator needs to understand the role of hospital staff and the functions and priorities of the emergency room in coping with these delays.
2. If the follow-up interview is conducted at the hospital, it must be held in a private setting which is free of outside interruptions. If a suitable arrangement cannot be made, the investigator should schedule the interview at a later time and place, e.g., the police station or the victim's home.
3. With the consent of the victim, it is appropriate that a support person who was present during the medical and evidence collection examination also be present during this interview.
4. The interviewer should be sympathetic and understanding of the victim's trauma, while at the same time effective in collecting all necessary information about the case.
5. The interviewer should establish him/herself as an ally of the victim and try to cushion the victim from pressures by family, friends, and other workers as well as from possible threats made by the attacker.
6. The victim should be allowed to tell his/her story without interruption by the interviewer. This will also afford the victim an opportunity to ventilate pent-up feelings in describing the assault. A special note should be made to record anything the attacker might have said in order to help establish the modus operandi or crime pattern.
7. The interviewer should go back over the story and, using the notes taken, ask specific questions covering any areas of the narrative that may have been incomplete or unclear.

TRANSPORTATION

Finally, transportation should be arranged when the patient is ready to leave the hospital. In some cases this will be provided by a family member, friend, or victim advocate who may have been called to the hospital for support. In other cases, transportation can be provided by the local police department as a community service.

SEXUALLY TRANSMITTED DISEASE (STD)

GENERAL INFORMATION

The risk of contracting a sexually transmitted disease as a consequence of sexual assault is not known; however, a *base-line for STD should always be established at the initial hospital examination.*

It could be helpful to the prosecution to have information on the presence or absence of STD's at the time of initial examination so an informed decision could be made as to whether to order additional tests of both the victim and the offender at some future date. If tests are initially negative but at the follow-up examination the results are positive, the presumption is that the disease was contracted from the assailant. Although every effort should be made to ascertain whether or not the assailant is infected, few suspects are apprehended by the time the victim receives initial hospital examination and testing. Therefore, some adult patients will request immediate treatment as a precautionary measure, and unless contraindicated, prophylaxis can be given at that time.

In the case of children the presence of a sexually transmitted disease is a strong indication of sexual abuse, and the presence of certain STD's might in some way link the offender to the crime. Although many infections, including gonorrhea and Herpes Simplex, can be transmitted to an infant at birth by an infected mother, all children beyond the first few months of infancy should be considered as having been sexually abused if an STD is present. Therefore, all cases of sexually transmitted disease in children should be reported to the appropriate law enforcement and child protective services, and to the local department of health.

Due to continuing research and discussion of the most effective treatment of sexually transmitted diseases specific to sexual assault victims, treatment regimens have not been included in this report. Instead, it is suggested that the reader consult the latest publication of the U.S. Department of Health and Human Services, Centers for Disease Control, for their latest treatment recommendations: "[Sexually Transmitted Diseases Treatment Guidelines](#)", 1985.

Traditionally, tests for sexually transmitted disease in sexual assault and abuse patients have been focused on screening tests for syphilis and gonorrhea. There are many types of sexually transmitted diseases; however, the following represents a brief overview of those most likely to be seen in the sexually abused patient.

CHLAMYDIA

In the past few years, the incidence of Chlamydia trachomatis has escalated dramatically within the general population and has become the most prevalent cause of sexually transmitted disease in the United States.

Chlamydial organisms are unusual in that they are completely dependent upon their host cell for energy and therefore are only able to survive outside of their host environment for the briefest period of time. Transmission of organism, except in the newborn who can acquire chlamydial conjunctivitis and/or pneumonitis during passage through the birth canal, is almost always through sexual contact.

In adults, chlamydial infections may be asymptomatic but more frequently are manifested in a wide variety of symptoms ranging from nonspecific urethritis to FID, orchitis, epididymitis, perihepatitis, and proctitis.

In children, the exact incidence of this problem is unclear but infection with this organism has been shown to be significantly more frequent than was previously recognized. Moreover, children appear to be asymptomatically infected more often than adults especially when the infection is oral or rectal.

When symptomatic, common clinical manifestations in females, other than those in pelvic inflammatory disease, are vaginal irritation, itching, and discharge. In males, a whitish urethral discharge, with or without painful urination, is a most common clinical picture.

In the past, hospitals were reluctant to routinely test for chlamydia because the method for detection was expensive and time consuming. Recently, inexpensive fluorescent antibody tests have become available and, although not as sensitive as chlamydial cultures, are adequate screening.

Unlike many other STD's, tests are available to detect circulating antibodies to chlamydia. The presence of these specific antibodies can provide corroborating evidence of a chlamydial infection.

Due to the prevalence and severity of the infection, it is recommended that this test be included in hospital protocols for detection of sexually transmitted disease.

GONOCOCCAL INFECTIONS

Gonococcal infections are caused by *Neisseria gonorrhea*. Although newborns may acquire gonococcal infections during passage through the birth canal, older children and adults almost always become infected with this organism through sexual contact. Clinical symptoms are myriad and include, but are not limited to, newborn conjunctivitis, pelvic inflammatory disease, orchitis epididymitis, urethritis, perihepatitis, proctitis, pharyngitis, vaginitis, and disseminated gonococcaemia.

The diagnosis of gonorrhea in the male can tentatively be made with a gram stain. However, a definitive diagnosis of gonorrhea is dependent in both males and females on a positive culture using Thayer Martin media and a differential sugar fermentation test.

Asymptomatic infections are not uncommon and should be treated. It is important to recognize that chlamydial infections commonly occur in conjunction with gonorrheal infections.

SYPHILIS

Syphilis is caused by *Treponema pallidum* and is transmitted by sexual contact except in cases of congenital syphilis and in those individuals infected by blood products or contaminated needles. Clinical signs and symptoms are dependent upon which of the four stages are manifested in the patient: primary, secondary, latent, or tertiary. The diagnosis of syphilis, especially in the tertiary and latent stages, requires a high level of suspicion. Most hospitals utilize serologic tests (either an RPR or VDRL) for the initial screening of patients suspected to have syphilis.

GENITAL HERPES SIMPLEX VIRUS INFECTION (HSV)

Genital herpes is the result of an infection with HSV type 1 or 2. This infection can be either symptomatic or asymptomatic and can reflect a primary, latent, or recurrent process. Over 90% of genital herpes infections are due to type 2 with the remaining 10% due to type 1.

Symptoms may be limited to several localized and painful vesicles or can be systemic and associated with fever, malaise, and swollen lymph nodes, in addition to the local herpetic vesicles.

Transmission of the virus occurs during both its active and latent phases. The diagnosis of genital herpes is usually obvious from the clinical picture but immunofluorescent and serologic tests, as well as cultures, can be used to confirm the diagnosis. It is important to recognize that the presence of HSV-2 is almost always acquired through sexual contact and that HSV-1, when present in the genital area, should also arouse a suspicion of sexual activity.

TRICHOMONAS VAGINALIS

Trichomonads are protozoans which can infect the genito-urinary tract of both males and females. The presence of these organisms, except in newborns who can become infected during passage through the birth canal, should be considered as indicators of sexual activity.

These organisms are easily identified by microscopically examining a fresh sample of urine or vaginal/urethral discharge. Trichomonads are approximately the size of white blood cells and are easily recognized by their unusual means of motility.

Symptoms of *Trichomonas* are usually localized to the site of the infection and consist of pruritus, pain on urination, urethral discharge in males, and vaginal and/or urethral discharge in females.

GENITAL AND ANAL WARTS

(Condyloma acuminatum)

These warts are due to infection with human papilloma virus (HPV), and except for newborns who can become infected during passage through the birth canal, transmission is almost always through sexual contact.

Condyloma acuminatum may occur as single or multiple lesions and are most often located on the glans areas of the penis or in the female on the labia, vagina, and/or cervix. They can also be found in the anal canal and occasionally in the mouth, on the lips, or on the breast nipples.

Condyloma usually appear as polyp like with irregular bright red surfaces. They produce few acute clinical manifestations other than obstruction (blockage of the urethra or the cervical outlet). The chronic presence of these lesions has been associated with malignant transformation. A diagnosis is usually made from the clinical appearance and location, but a tissue biopsy may occasionally be needed to differentiate these from other warts.

Autoinnoculation has been identified rarely and should be a diagnosis of exclusion.

NONSPECIFIC VAGINITIS

This is probably the most common form of vaginal infection in post pubescent sexually active females and represents the complex interaction of several organisms.

Gardnerella vaginalis is the organism most frequently identified in women with nonspecific vaginitis and it is often accompanied by anaerobes, Mycoplasma hominis, and Ureaplasma urealyticum.

Infections may be either asymptomatic or associated with local vaginal/urethral discharge, pruritus, and burning on urination. The vaginal discharge is usually whitish gray and is striking because of its 'fish-like odor', especially when hydrogen peroxide is added to it.

SEXUAL ASSAULT and AIDS: Information about AIDS and AIDS Testing

Women and men who have been sexually assaulted may be concerned about possible exposure to the HIV (AIDS) virus and may want to be tested for the virus.

It is impossible to be infected with the HIV virus from a sexual assault: (1) if the assailant does not have AIDS or has not been infected with the virus; (2) if there was not direct contact with semen or blood of the assailant during the assault. While it is possible to be exposed to AIDS from a single contact with an infected individual, a single contact, as in sexual assault, does not significantly increase one's risk for contracting AIDS. To date, there is no information indicating that sexual assailants are more at risk for AIDS than the population in general. Factors which might increase infection from a single contact with an infected assailant are: rectal intercourse with ejaculation; vaginal or rectal intercourse with ejaculation and pre-existing vaginal or rectal infections, especially sexually transmitted diseases; vaginal intercourse with ejaculation during menstruation. *In general, a sexual assault does not significantly change a person's risk for AIDS.*

Because the time varies when the virus can be detected, it is recommended that those victims who wish to be tested have a minimum of three tests following the assault: the first test soon after the assault as a baseline (which will tell the victim if s/he has been exposed to AIDS prior to the assault); a second test at three (3) months after the assault (this is the earliest that reliable results can be detected); and a third test at nine (9) months after the assault. If this third test is negative, one can be reasonably sure that s/he is not infected with the virus from the assault. A fourth test at one year after the assault is optional. It is recommended that testing be done at an anonymous designated testing site offered through the Michigan Department of Public Health to ensure quality testing and pre- and post-test counseling.

Victims are encouraged to discuss their concerns about AIDS with a rape crisis counselor.

CHILD PROTOCOL

GENERAL INFORMATION

Sexual abuse of children falls into three major categories:

1. *Sexual abuse of a child by a stranger, many times involving kidnapping and/or the use of a weapon.* These assaults usually occur on a random basis, are more likely to result in severe physical injuries to the child, and account for a growing number of sex-related deaths of children.
2. *Sexual abuse of a child through the use of pornographic materials and exploitation.* Many of those involved are 'runaway' or 'throwaway' children who are dependent upon the exploiters for physical survival, and in some cases, even affection.
3. *Sexual abuse of a child by a family member or other person known to the child whom the child trusts to some degree.*

The abuser in *intra-familial child sexual abuse* is related to the child victim through blood, marriage, adoption, or common living arrangement, and generally involves the following relationships:

1. The abuser is legally related and a member of the child victim's immediate family (natural or adoptive parent, sibling).
2. The abuser is a member of the child victim's extended family (e.g., grandparent, aunt/uncle, cousin).
3. The abuser is not legally related but is seen by the child as part of the immediate family because the abuser lives or has daily contact with the family (step-parent, guardian/foster parent, male or female friend of parent who is commonly viewed as the 'psychological parent').

The abuser in *extra-familial child sexual abuse* is not considered a part of the child's family; however, this person usually has an opportunity for frequent contact with the child and/or represents an authority figure which the child may believe to be synonymous with trustworthiness. These relationships include but are not limited to the following:

Neighbor, day care/school employee, clergy, scout leader, friend of family, baby-sitter.

Many children are sexually abused in some way over a period of years. Long-term abuse in intra-familial situations may begin when the child is three or four years of age or younger, and continue well into adolescence or even after the child leaves home.

Until recently, there has been little opportunity for many young children to learn what constitutes appropriate and inappropriate physical contact with an adult or older child. Secrecy associated with the sexual activity or threats of personal harm to the child or to the child's family, may cause the child to sense that something is wrong. However, unless educated about proper and improper touching and the importance of telling someone when inappropriate behavior occurs, many children do not understand that they should report the incident(s) or are afraid to do so. The situation is made even more complicated when the offender is someone whom the child loves and/or trusts, such as a parent or other close family member.

In some instances, intra-familial abuse may be restricted to fondling or gentle touching; other instances may begin this way and escalate to manual penetration or full intercourse usually after an extended period of time. The family member is usually viewed as an authority who 'must know what is best', which often allows the perpetrator to be able to convince the child that these types of sexual contacts are normal and take place in other families.

Some children become adolescents before realizing, through normal discussions with friends about family life and

events, that the sexual contact they have experienced is wrong and does not usually occur in most households. By this time, however, the child may have assumed a great amount of guilt about the sexual activities and will be even more reluctant to reveal the situation to an adult or other family member.

When an attempt is made to talk to someone about the abuse many children are unable to communicate what is happening. Even when the child is quite verbal, the listener may dismiss the story as ‘make believe’ or accuse the child of lying. When no action is taken to protect the child from further abuse, the child may decline to initiate the subject again.

TREATMENT PLAN

FACILITY

Because of the inability of most children to secure medical treatment on their own, the majority of sexually abused children do not receive immediate medical attention. When medical attention is received, it is usually at the request of a third party. This request is frequently made by a parent who notices unusual genital soreness, discharge or urinary problems, by a teacher who sees a sudden change in the child’s behavior, by a relative who suspects physical abuse, or by a physician who discovers gonorrhea from a vaginal, urethral, or throat culture.

Ideally, each hospital designated to treat adult victims of sexual assault will also have a multi-disciplinary team, available on an on-call basis, for the evaluation and examination of child sexual abuse cases. This team should consist of a pediatrician for the physical examination and a social worker and/or nurse to provide patient support and coordination with the law enforcement and child protection agencies. An obstetrician/gynecologist should also be available on an on-call basis to provide consultation and follow-up when necessary. Each team member must be trained in the management and psychodynamics of the sexually abused child.

In the absence of such a specialized team, the minimum requirements should be a readily available physician and nurse, both of whom are trained in the medical and psychodynamic aspects of child sexual abuse.

INTAKE

Children are often brought to the hospital by a police officer and/or parents who are seeking examination and treatment. When the child is accompanied by an officer, the officer should be directed immediately to the emergency/pediatric department so that a brief history of the assault can be provided to the attending medical staff.

If the child’s parent or guardian is present, he or she should be asked if there is any additional information about the event which should be shared with the physician. In cases involving young children, the parent/guardian also should be asked to provide the physician with the child’s medical history.

Since children many times will tell health professionals things they may not tell in the presence of parents or other adults, *adolescents and older children should be encouraged to provide much of their own medical history, as appropriate.* This interview should be conducted in a private area, and information regarding sexual history (of both males and females), menstrual history, and use of birth control should be recorded.

The child’s parents/guardians should be informed about and prepared for the physical examination by the nurse or the physician. They should also be told what specific lab tests will be done, the purpose of each test, and when the results will be available.

REPORTING

Every case of known or suspected history of child sexual abuse should be reported to the appropriate child protection services and/or legal agencies, be considered a medical emergency, and be seen without delay only after other acute cases, such as trauma or ingestions.

SUPPORT PERSONNEL

Under no circumstances should the child be left alone. Arrangements must be made to provide a support person who can establish a good rapport with the child.

As with adults, an important first step in intervention is to help children regain a sense of control over their bodies. For adolescents, this many times can be accomplished by allowing them a choice of the support person to be present during the physical examination. This support person could be a trained hospital social worker or nurse, a trained victim advocate, or a family member.

A support person of the same sex as the child can be quite reassuring and, in fact, may be required by many institutions for staff protection.

CONSENT

Consent to conduct a medical examination and collect physical evidence should be obtained from parents/guardians of all children under the age of 18.

Fortunately, there are few situations where the parent/guardian refuses consent to these procedures. However, if consent cannot be obtained from the parent or guardian of the child and if the child is in danger from his or her surroundings and requires immediate attention, many jurisdictions provide for the attending physician to take the child into custody at the hospital for a specific amount of time. This will allow the medical staff to provide diagnosis and treatment, the child protective and law enforcement agencies to investigate the abuse, and at least on a short-term basis, protection of the child from further abuse. *In such cases, procedures established by policy or by law should be carefully followed in each jurisdiction.*

CHILD INTERVIEWS

Many sexually abused children who are brought to a hospital for examination and treatment have not yet been interviewed by law enforcement or child protective service workers. Therefore, it is likely that the examining physician will be the first person to interview the child about the event(s). The following guidelines will assist in this process.

Interviewing children about abuse of any kind, physical or sexual, requires special skills. It can often be difficult to get the child to talk or to understand what the child says. Many professionals are not really comfortable with children and may be unaware of techniques for establishing a rapport with children.

When children are asked about their sexual activities with adults or other children, many times their inability or reluctance to answer these types of questions is due to embarrassment, shyness, a fear of being thought of as a 'tattletale' or disloyal, or simply due to a lack of understanding of the question itself.

With children, to a much greater extent than with adults, interviewers must be aware of the long-term ramifications of their questions. While the immediate goal is to elicit the clearest possible information from the child, the interviewer should be aware of his/her own feelings about child sexual abuse and not communicate any attitudes which might create or increase the child's trauma. This is especially important in cases of sexual abuse with a family member where, *in the child's mind*, the action may have been viewed as one of affection.

Prior to the interview, it is important to determine what reactions the child has been exposed to following the disclosure of the abuse. For instance, the medical professional should try to ascertain if the child's family has been supportive, panicked, ambivalent, disbelieving, angry, or blaming. Also, parents and others who have regular contact with the child should be questioned, whenever possible, about any behavioral changes they have observed.

Indicators of child sexual abuse perpetrated by a family member or other trusted individual, however, are not always concrete. Therefore, hospital staff should be alert for signals from the parent/guardian which may indicate sexual abuse, including but not limited to the following:

Standard Recommended Procedures for the Emergency Treatment of Sexual Assault Victims

1. the child stays inside the house more frequently
2. the child does not want to go to school
3. the child cries without provocation
4. the child bathes excessively
5. the child exhibits a sudden onset of bed wetting

An assessment of the child's emotional state is a vital part of the interview process. This is an age-dependent interpretation, such as how the child relates, his or her body posture, and the language used. It is also important to assess the child's verbal skills level and to use terms that are understandable to the child. This assessment can many times be accomplished by asking topical questions about family, school, television, and everyday events. After a degree of rapport has been established, the child can then be asked to describe what happened.

KEY INTERVIEWING TECHNIQUES

The interviewer should be supportive and sensitive through tone of voice, body expression, and the maintenance of eye contact. The interviewer should also sit at eye-level with the child so that the child is not intimidated and so that the interviewer is perceived as genuinely interested.

The child must be allowed to tell the story with as few interruptions as possible and to use his/her own words in describing what happened.

It is absolutely vital that the child be believed at all times, especially in cases of disputed accounts by adults. The child's story should be taken at face value.

Value judgments and expressions of shock or surprise should be avoided.

It must be made very clear to the child, as often as needed throughout the interview, *that the child was not at fault for what happened* and that medical staff are there to help and protect him/her.

Statements made by the child should be recorded accurately. The child should not be led in such a manner that he or she answers questions to 'please' the interviewer.

Younger children often have problems with times and dates. In order to establish a time frame in which the abuse occurred, it can help to discuss favorite events or activities. These could include asking about television shows, a vacation or trip to see a relative, going to the zoo, or shopping.

Younger children also are somewhat concrete and have a short span of attention. Therefore, the interviewer should avoid long and open-ended questions and provide short rest periods at appropriate intervals during the interview.

The use of interview aids is extremely helpful. Drawings, pictures, and anatomically correct dolls are particularly effective.

It may be necessary for the interviewer to follow up the child's description with clarifying questions in order to learn exactly what happened. For instance, in situations where penetration did not occur but where there was other sexual contact, the child may not at first differentiate between oral and manual stimulation.

Finally, it is important for all interviewers to be aware that many times it is necessary to conduct more than one interview over a period of days in order to ascertain the circumstances of the abuse.

MEDICAL HISTORY INTERVIEW

The most experienced professional medical staff person available should conduct a *preliminary medical history interview* of the child. The purpose of this interview is to obtain the information necessary to conduct a proper medical examination and possible collection of physical evidence. *A more thorough, detailed investigative history will be obtained by law enforcement and child protective agency personnel at a later time.*

The interview should be held in a private room adjacent to the emergency or pediatrics department and *must be free from interruptions. The interviewer should explain his/her need to know what happened and what procedures will be done.* He/she should also use simple terms, including the child's vocabulary for body parts, acts, and people.

Attending Personnel

As few persons as possible should be present during the medical interview/evaluation or examination/evidence collection process. Attending personnel should consist of the examining physician, an authorized support person, and/or nurse. *Those persons involved in the investigation, such as law enforcement or child protective agency representatives, should not be in attendance during these procedures.*

Presence of Parent/Guardian

In all cases of known or suspected child sexual abuse, the medical person in charge must decide whether or not the presence of a parent or guardian is desirable during the evaluation or medical examination.

Many times it is not preferable to have a family member present during the medical history interview or physical examination of the child, in order to minimize confusion and additional trauma to the child, and many times, for the purpose of obtaining information that might otherwise be censored. Some parents may be so emotionally distraught or disbelieving upon hearing the child's narrative that their presence has a negative impact upon the child and the interview/examination process. When these situations occur, the parent/guardian should be taken to a private area and provided with support and comfort. However, if the child expresses a need for support from a parent/guardian, and that parent/guardian is *not* suspected of perpetrating the abuse, their presence may be appropriate *if they are supportive to the child.*

Under no circumstances, however, should the interview/evaluation be held in the presence of a parent/guardian who is suspected of perpetrating the abuse.

MEDICAL/EVIDENTIARY EXAMINATION

The medical examination should consist of a general physical examination, a genital examination, and where appropriate, the collection of physical evidence.

All equipment, containers, and other materials necessary for the examination and evidence collection procedures should already be in the room prior to the child's entry.

Basic equipment should include the following:

- 1 Routine examination equipment
- 2 Appropriate lab slips and cultures
- 3 Blood collection equipment
- 4 Speculum for adolescent females
- 5 Woods Lamp (Ultraviolet illuminator)
- 6 Evidence collection kit (if appropriate)
- 7 All medical and evidence collection paperwork

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In preparation for the examination, the child should be undressed (except for underpants), and be wearing an examination gown. Help with this process can be provided by the attending nurse, support person, and/or parent or guardian (if present). Special considerations which will increase the child's sense of well-being include the following:

1. Throughout the examination, great care must be taken to minimize additional trauma to the child. For instance, many children have never before been in a hospital environment. Factors such as the presence of unfamiliar equipment, most of which can be quite 'scary' in appearance, and the necessity of darkening the examining room in order to conduct the Wood's Lamp procedure properly can be extremely disconcerting and frightening to a child. Therefore, each step in the examination process should be explained to the child prior to its being performed.
2. It is important for the examiner to be aware that children interpret statements literally. For example, statements such as "I'm doing cultures to see if there are bugs in there!" should be avoided. Children may think this means they are dirty or have something 'alive' inside them.
3. The examiner should reinforce the idea that the child is not 'damaged goods' or irrevocably marked in some obvious way.
4. The child should not be restrained in order to do the examination and/or to gather evidence. If the child is visibly upset, the physician should determine what measures are to be taken to reduce his/her anxiety.

Some cases may require the use of sedation; *however, it is recommended that general anesthesia not be administered except in the most extreme cases, such as in a life-threatening situation or when the removal of a foreign object would cause undue pain and trauma to the child.* Careful explanation of any sedation or anesthetic should be provided to both the family and to the child.

EVIDENCE COLLECTION

Regardless of when the assault or last sexual contact might have occurred, *valuable evidence can still be obtained through a medical examination and interview of the child.* Therefore, *it is vital* that such an examination still be performed and that *all paperwork be completed*, whether or not evidence specimens are collected.

If it was determined during the medical history interview that the *last sexual contact took place more than 72 hours prior to the hospital visit*, the percentage of cases where trace evidence is still present on the child's body or clothing will be significantly low. This is most common in situations involving long-term abuse. Therefore, a careful evaluation of each case must be made to decide which, if any, evidence collection procedures should be implemented.

If it was established that the last sexual contact *took place within the prior 72 hours or if the time frame could not be determined*, then evidence procedures should be implemented according to the instructions given for adults, on pages 10–19 of this report, but with the following modifications:

- With young children, the amount of blood collected for forensic purposes should be limited to only 3 milliliters.
- If it is determined that simultaneous use of two rectal swabs is not desirable, swabs should be used one at a time.
- For the young female child and the adolescent female who is too traumatized to have a full pelvic examination, evidence specimens can be obtained by gently swabbing the exterior vaginal areas, using a moist swab or pipette.
- *It is recommended that hair standards not be taken from children at the time of the initial examination.*
- *Only under the most extreme circumstances, and only after it has been determined that hair evidence is crucial to the successful prosecution of the offender, should a child's head hair be pulled.*
- *It is further recommended that pubic hairs not to be pulled from children.*

MEDICAL EXAMINATION

General Information

An immediate assessment of the child's status must be made to determine the presence of any significant vaginal, rectal, penile, or other major trauma/sites of bleeding. If present, their control/stabilization must be the priority.

The more common medical indicators of child sexual abuse are:

1. the presence of sexually transmitted disease
2. unexplained vaginal bleeding, discharge, or trauma
3. inappropriate sexual behavior for the child's age
4. suspicious stains or blood in the underwear
5. lesions, bruising, or swelling of the genital area not consistent with history
6. pain in the anal or genital area
7. unexplained pain or soreness in the abdominal area

The presence of genital and/or other types of physical injuries or abnormalities can serve as corroborative evidence and should be carefully recorded in the medical record. The location of these injuries should be recorded on drawings of the young female and male body. Any specific explanations given by the child for the injury should also be included in the medical record, using the child's exact words if possible.

The medical examination of a sexually abused child may, in many cases, be negative. Nonetheless, the lack of any specific injury/finding *in no way detracts from the likelihood that the abuse occurred*. A lack of physical finding may be due to many factors, such as the degree of force used, the type of activity perpetrated upon the child, and the diagnostic skill of the examiner.

Prior to the full examination, a Wood's Lamp should be passed over the child. Whenever seminal fluid is present, it may fluoresce a characteristic light blue color. If present, specimens from these areas should be taken for submission to the forensic laboratory. The presence of any bruises, abrasions, lacerations, burns, or other dermatologic lesions should be recorded. An attempt should be made to estimate the age of the injury; *i.e.*, noting the color of a hematoma and the degree of healing of an abrasion. Any fractures, loose or absent teeth, grab marks, suction or bite marks should be recorded, all of which are helpful in providing further confirmation of victimization.

Examination of the Anal, Perianal, and Perineal Areas

The attending physician must decide on a case-by-case basis the extent to which rectal examinations should be performed with both female and male children during the initial examination.

Recent anal trauma may manifest itself by perianal erythema, edema or contusions, skin tags, and spasm of the anal sphincter. An examination of the sphincter tone for spasm or laxity is important, and any findings should be noted. Use of a colposcope has been of value in detecting small scars and striations previously not visible to the unaided eye.

If anal tears or bleeding are present, an anoscopy should be performed.

Although 'gaping' of the anus can be the result of certain chronic medical conditions, such as constipation, it can also be an indicator of chronic sexual abuse of the rectum.

Genitalia

It often is helpful at the beginning of the genital examination to use Tanner Staging (a method to estimate the level of sexual maturation of children).

Female Genital Examination

The attending physician must also decide on a case-by-case basis the extent to which vaginal examinations should be performed.

For the young female child, a complete gynecological exam is not recommended unless there is evidence or reasonable suspicion of genital trauma. However, a careful visual inspection should still be made.

In all cases where a pelvic examination is conducted, a small speculum should always be used. For patient comfort, the speculum can be moistened with warm water, *but no lubricants of any kind should be used.*

With the young child present on the mother/caretaker's lap (if appropriate), or supine on the examining table, the vaginal and perineal areas are inspected. The presence of erythema, hematomas, excoriations, abrasions, old scars, and bleeding as well as the overall appearance of the introitus and the interlabial spread should be recorded. The urethral meatus should be examined for any signs of trauma or abnormal dilation.

An attempt to visualize the hymen is usually successful in prepubescent girls. The hymen most often is a medically thin circular membrane originating from the edges of the vaginal entrance. Most frequently there is a central opening or openings.

There are anatomical variations in both the size and types of openings ranging from unusually small and/or imperforate to completely absent. Hymenal damage can occur from causes other than intercourse or manipulation, such as athletic activities or falls. *Conversely, the presence of the untraumatized hymen does not preclude ejaculation through an intact hymen.*

Inspection should also be directed to any discharge (seminal or purulent), as well as odors, evidence of a foreign body, tears, skin tags, and tenderness.

Male Genital Examination

Both the glans and the scrotal area are targets of trauma in acute sexual assault.

Evidence of erythema, bruises, suction marks, excoriations, burns, or lacerations of the glans and frenulum should be recorded. The presence of testicular or prostatic tenderness or discharge from the urethra are important signs and may reflect trauma or infection.

NON-AUTHORIZATION TO RELEASE EVIDENCE

Although there have been instances where a parent or guardian, acting on behalf of the child, has refused to authorize the release of evidence to law enforcement, the actual incidence of this has been very low.

If this does happen, the examining physician may be able to sign for the release in the best interests of the child. If the local child protective service or law enforcement agency are not already involved in the case, they should be contacted for assistance by hospital personnel. Each individual hospital should ascertain policy in their particular legal jurisdiction.

POST-EXAMINATION INFORMATION

PATIENT INFORMATION FORM

A patient information form should be filled out, providing the same information as is given to the adult patient. The patient's parent or guardian should sign the form at the bottom and be given the original copy.

The provision of psychological services for children and their parents or guardian is just as important as for adults. If this service is not available through the hospital, a referral should be made to an appropriate agency or individual with approved credentials and training in the field of child sexual abuse.

It is extremely important that children return for a follow-up visit within one week to re-evaluate any genital or other injuries, and to perform follow-up cultures, if necessary.

This visit will also provide the examining team an opportunity to assess how well the child and/or family are handling the stress and whether or not counseling has been received or is necessary.

LAW ENFORCEMENT INTERVIEW

It is the responsibility of the investigating officer to ascertain the most supportive environment for the child during the follow-up law enforcement interview.

The goal of the juvenile office/investigator's interview with the child victim of sexual abuse, whether the abuse was committed by a stranger, family member, or other trusted adult, is twofold:

1. To obtain accurate information needed for case investigation.
2. To avoid further trauma to the child.

Ideally, the law enforcement interview would include the presence of a child protective services representative, so that the trauma of multiple interviews is curtailed. It also can be helpful to have a support person present who established a good rapport with the child during the medical examination/interview. This type of 'joint response team' effort has proven effective in many areas of the country. To avoid confusion, however, *it is important that only one person be the primary interviewer.* In all cases, the people present during the interview must be there for a specific purpose and must be psychologically supportive to the child.

Depending upon the circumstances surrounding the case, some child victims will be interviewed by law enforcement and/or child protective service representatives at a location away from the hospital, such as the child's home, school, or an agency facility. However, space adjacent to the emergency room or pediatrics unit of the examining hospital should always be provided for those situations where the interview must be held immediately after the medical examination. Privacy is, of course, crucial to the success of this interview.

Great care should be taken by the juvenile officer/investigator to minimize visibility of weapons and standard equipment (such as handcuffs and nightsticks) carried during the interview so that the child is not further intimidated or traumatized.

When the interview is concluded, it is important for the interviewer to thank the child for his or her cooperation, and with older children, to give them a telephone number where the interviewer can be reached if they have any further problems or questions.

PRESENCE OF PARENT/GUARDIAN

Although some children are more relaxed and informative without a parent/guardian present, others, particularly very young children, may not be willing to cooperate in an interview without such support. Also, parents or relatives may be the only adults to whom the child will talk. When this happens, questions can be directed to the child through these family members, *but only after initial efforts of the interviewer to directly talk with the child are unsuccessful.*

Standard Recommended Procedures for the Emergency Treatment of Sexual Assault Victims

If a parent or guardian is present, the purpose of the interview should be explained in a straight-forward manner, and cooperation should be elicited to reassure the child that it is 'safe' to talk with the interviewer. The parent/guardian should also be told that any facial expressions of shock, disbelief or disapproval, or any verbal or physical signals to the child could impede the investigation.

As with the medical history interview, if it is suspected that the parent/guardian is the perpetrator, *then under no* circumstances *should the* interview of the child be held in *his/her presence*.

SUPPORTING MATERIAL

1. ENROLLED HOUSE BILL No. 4623
2. MEDICAL FORMS (Rev. 9/94)
 - Release of Information and Evidence
 - Patient Examination Form
 - Patient Treatment Form
 - Information to Patient
3. 24-HOUR ASSAULT CRISIS CENTERS IN MICHIGAN
4. INFORMATION FOR SURVIVORS OF SEXUAL ASSAULT
5. MSP KIT INSTRUCTION SHEET

ENROLLED HOUSE BILL No. 4623

MASTER COPY

STATE OF MICHIGAN

84TH LEGISLATURE

REGULAR SESSION OF 1988

Introduced by Rep. Saunders

AN ACT to amend Act No. 368 of the Public Acts of 1978, entitled as amended “An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection, and use of data and information; to provide for the transfer of property; to provide certain immunity from liability, to provide for penalties and remedies; and to repeal certain sets and parts of acts,” as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws, by adding section 21527.

The People of the State of Michigan enact:

Section 1. Act No. 368 of the Public Acts of 1978, as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws, is amended by adding section 21527 to read as follows:

Sec. 21527. (1) If an individual alleges to a physician or other member of the attending or admitting staff of a hospital that within the preceding 24 hours the individual has been the victim of criminal sexual conduct under sections 520a to 520l of the Michigan penal code, Act No. 328 of the Public Acts of 1931, being sections 750.520a to 750.520l of the Michigan Compiled Laws, the attending health care personnel responsible for examining or treating the individual immediately shall inform the individual of the availability of a sexual assault evidence kit and, with the consent of the individual, shall perform or have performed on the individual the procedures required by the sexual assault evidence kit.

(2) For the purposes of this section, the administration of a sexual assault evidence kit is not a medical procedure.

(3) As used in this section, “sexual assault evidence kit” means a standardized set of equipment and written procedures approved by the department of state police which have been designed to be administered to an individual principally for the purpose of gathering evidence of sexual conduct which evidence is of the type offered in court by the forensic science division of the department of state police for prosecuting a case of criminal sexual conduct under sections 520a to 520l of the Michigan penal code, Act No. 328 of the Public Acts Of 1931.

TO THE PATIENT:

MEDICAL FORMS

FOLLOWING A SEXUAL ASSAULT

The Examination

The doctor and nurse will interview you in order to decide what injuries require attention and treatment. They will need to examine you carefully, render medical assistance, and collect evidence of the assault.

Your private insurance or Medicaid should pay the cost of the medical examination and treatment. If you are not covered by insurance, you may be eligible to file a claim with the Crime Victims' Compensation Board. For information, contact them at P.O. Box 30026, Lansing, 48909, 517-373-7373.

Possible Complications

In order to determine whether you have contracted any infections, such as venereal disease or AIDS, or became pregnant from the sexual assault, various tests will be performed. Options for dealing with these complications should be discussed with you. Follow-up with your own health-care provider is recommended.

Evidence Collection

The signs of a sexual assault include the appearance of your body and clothing; indications of force, such as bruises; injuries; and foreign matter on your person. The doctor and nurse will carefully obtain clothing, protect them, and send them to a police laboratory for analysis. Should you decide to prosecute the assailant, the information will be available to help prove the case in court.

The police or medical personnel may keep your clothing for evidence. You will be given a receipt for the items. Replacement clothing may be given to you by the hospital or local rape crisis center.

Your Emotions

It is normal for you to have intense, uncomfortable feelings after a sexual assault. Here is a description of the stages victims often experience after a crisis such as rape:

- 1) The Acute Phase (immediately following the assault) Feeling numb, degraded, stunned, afraid, in shock, angry, unable to eat or sleep, jumpy, tearful, disbelieving, etc.
- 2) The Outward Resolution Phase Feeling more "back to normal," at least to outward appearances, trying to forget the assault.
- 3) The Re-integration Phase (Several months to years after the assault) Gradual healing.

24-HOUR ASSAULT CRISIS CENTERS IN MICHIGAN

A list of 24-hour assault crisis centers appeared on this page. For a current list of sexual assault service providers, see Appendix A, above.

IMPORTANT INFORMATION FOR THE SURVIVOR OF SEXUAL ASSAULT

If you have been sexually assaulted:

- Get to a safe place.
- Do not shower, bathe, douche, wash your hands, brush your teeth, use the toilet, change or destroy your clothing, or straighten up the area where the assault occurred.
- Call the police.
- Get medical attention as soon as possible. Contact someone you trust, a family member, or close friend.'
- Call your local rape crisis center for support and information.'

Defining Sexual Assault

Sexual assault and rape are defined as any unwanted sexual act or contact that is attempted or completed by force, threat of force or coercion. In Michigan, the legal term for this type of crime is Criminal Sexual Conduct.

Why Sexual Assault Occurs

Many victims think that the sexual assault was their fault. Once they know some facts, however, they know that they were not to blame. Here are some important things to keep in mind about sexual assault.

- Sexual assault is a crime of violence and control, not an impulsive act of passion committed by a sexually unfulfilled person.
- Most sexual assaults are carefully planned; assailants choose victim because they are available and vulnerable, riot sexy and attractive. Women and girls of all ages, races, socio-economic groups, neighborhoods and lifestyles can become victim, as can men and boys.
- No one asks to be sexually assaulted, to be hurt, humiliated, or threatened with death. Fear of death, threat of violence, or physical brutality can immobilize anyone.
- Very often sexual assault is committed in the victim's own home by someone the victim knows—a relative, friend, neighbor, or other acquaintance

Your Feelings

You might feel frightened, outraged, powerless, dirty, vulnerable, violated, shocked, or disbelieving, thinking that the assault didn't really happen. You may have trouble concentrating and experience depression, nightmares, or a loss of appetite. You may find that your lifestyle is disrupted and wonder if it will ever return to normal. You may be afraid to leave your house and find it difficult to trust anyone. You may wonder what others think and believe that no one could possibly understand how you feel. All of these reactions are common and natural.

Your Family and Friends

Your family and friends will be struggling with feelings of their own. But some of them may not be able to talk with you about the assault, your feelings or theirs. They may mistakenly blame you or themselves for the assault. They may want to be protective and make decisions for you or they may avoid closeness. Understanding the feelings of your family and friends does not mean that you must take responsibility for helping them cope with their feelings, especially when you need to be dealing with your own.

Medical Attention

If you have been sexually assaulted, you should get medical attention from an emergency room or other health care provider as soon as possible (and preferably within 24 hours of the assault). There are four important reasons why you need to do so:

- To determine if you have been injured in any way.
- To collect medical evidence in case you decide to prosecute at a later time.
- To be tested for pregnancy and sexually transmitted disease that may have resulted from the assault.
- To ease your fears and help you begin to take the first steps toward regaining control of your life.

Police Involvement

The law does not require you to report your assault to the police; however, survivors are strongly encouraged to do so. Reporting and prosecuting sexual assault can help get rapists off the streets and make our communities safer for all of us.

If you decide to report the crime, the police will ask for information about the assailant's description and about the circumstances of the crime. It is important that you be as complete and accurate as possible in relating the information they request. Photographs may be taken to document the visible signs of the assault. You will be asked to sign a formal statement about the assault; be sure to read it over carefully and correct any errors before you sign it. If you report the crime, you are not obligated to pursue prosecution.

Prosecution

If the assailant is arrested and your case proceeds to prosecution, the Prosecutors Office handles the case; you do not need to hire your own attorney. The entire process, from arrest to trial, can be lengthy, with many delays. You will be called to identify the assailant and testify about the assault before a judge and possibly a jury. It will be difficult emotionally for you to recall and repeat the details of the assault. The assailant's attorney will attempt to discredit you, e.g., by suggesting that you were mistaken or to blame. The prosecutor and/or a rape crisis or victim/witness advocate can help you understand the proceedings and to anticipate all questions beforehand so that you are prepared and strong.

Getting Help

Many rape crisis centers provide 24-hour counseling, support, information, and referrals for survivors of sexual assault, as well as for their family and friends. Trained counselors understand your feelings, will listen and help you deal with what you are feeling. They can also help you to make decisions about medical and legal matters and to obtain follow-up care. Advocates may also be available to accompany you to the hospital, police department, and to court.

For the name and phone number of a rape crisis program in your community, check the Yellow Pages or contact the Sexual Assault Information Network of Michigan between 9 a.m. and 5 p.m. Monday–Friday for information by calling (517) 371-7140.

Note: *Information provided is based on the booklet 'Surviving Sexual Assault,' published by the Los Angeles Commission on Assaults Against Women and a pamphlet by the same title written by Pauline Fisher and Judy Trompeter of the Council on Domestic Violence and Sexual Assault, Midland, Michigan.*

MICHIGAN STATE POLICE

SEXUAL ASSAULT EVIDENCE COLLECTION

KIT INSTRUCTION SHEET

***NOTE:** This kit has been designed to assist physicians in the collection of evidentiary specimens for examination by the crime laboratory serving the police agency investigating cases of alleged sexual assault. Your cooperation is requested in the collection of the following samples.*

EVIDENTIARY SPECIMENS

FIBERS AND/OR FOREIGN MATTER: (May relate victim to a particular person or place)

Collect any and all material found on victim's body which may have originated from assailant or from scene of the alleged assault. (For example: plant material, fibers, hair, dried secretions, etc.) Place in envelope labeled "Miscellaneous," seal, and fill in information requested.

HEAD HAIR COMBINGS: (May contain hairs from assailant)

Remove paper towel and comb provided in the "Head Hair Combing" envelope. Place paper towel under victim's head and comb entire head area in downward strokes so that any loose hair will fall on paper towel. Place comb in center of towel and fold towel in manner to retain both comb and any loose hair present.

PUBIC HAIR COMBINGS: (May contain hair from assailant)

Remove paper towel and comb provided in the "Pubic Hair Combing" envelope. Place paper towel under victim's genital area and comb entire pubic hair area in downward strokes so that any loose hair will fall on paper towel. Place comb in center of towel and fold towel in manner to retain both comb and hair present.

SWABS AND SMEARS: (Swabs for examination of semen and blood groups, smears for spermatozoa)

***NOTE:** Extreme caution should be used in order not to mix swabs and smears from different areas. Do not stain or chemically fix slides. Do not use any type of lubricant in obtaining swab samples.*

- A) Remove slides from oral, rectal, and vaginal slide holders.
- B) Using two swabs for each area, swab oral, rectal, and vaginal tract.
- C) Using both swabs from each area, make two smears from each area.
- D) After smears have been made, place swabs used on appropriate slides and allow swabs and smears to air dry.
- E) After smears have air dried, mark frosted end of slides in the following manner:

O for Oral | R for Rectal | V for Vaginal

Return slides to appropriate slide holder and fill in information requested on labels.

- F) Snap off approximately 2" to 3" of wooden shaft on swabs and place in appropriate swab envelopes. Seal and fill in information requested.

KNOWN SPECIMENS FROM VICTIM

NOTE: In order to determine if there is any material from an assailant, it is necessary to determine that materials came from the patient by comparing the questioned evidentiary material with known specimens from the patient. For this reason it is requested you collect the following:

KNOWN BLOOD SAMPLES: (To be examined for various blood and enzyme groups)

Since a blood sample must be drawn by the hospital for VDRL, please collect an additional blood sample using a lavender stoppered (EDTA) blood collection tube for the crime laboratory.

NOTE: 2 ml of blood is sufficient for crime laboratory's use.

KNOWN SALIVA SAMPLE AND SMEAR: (Used to determine victim's blood group and secretor status)

Remove paper disk from "Saliva Sample" envelope and have victim place disk in her/his mouth and thoroughly saturate with saliva. Allow paper disk to air dry, then return to envelope. Seal and fill in information requested.

PULLED HEAD HAIRS: (To be compared with hairs from head hair combings)

NOTE: Do not use forceps for this procedure. Pull (do not cut) 12 strands of the victim's head hair from various regions of the scalp. Place hairs in envelope labeled "Pulled Head Hair," seal, and fill in information requested.

PULLED PUBIC HAIRS: (To be compared with hairs from pubic hair combings)

NOTE: Do not use forceps for this procedure.

Pull (do not cut) 6–8 strands of pubic hair from victim's pubic area. Place hairs in envelope labeled "Pulled Pubic Hair," seal, and fill in information requested.

NOTE: Fill in information requested on front of kit envelope. Place all samples collected in kit envelope. Moisten gummed flap on kit envelope and seal envelope. Place orange evidence seal on flap where indicated. Hand sealed envelope to police officer after he has signed Item #45 on the forms and the chain of custody on envelope. Advise police officer to send sealed envelope to the crime laboratory as soon as possible.

YOUR COOPERATION IN THIS PROGRAM WILL ASSIST IN THE RIGHTFUL PROSECUTION OF SEXUAL ASSAILANTS.

WE THANK YOU FOR YOUR ASSISTANCE.